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FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G178	A. BUILDING _____ B. WING _____	07/17/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
R C M OF WASHINGTON	1307 45TH PLACE, SE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS A recertification survey was conducted from July 15, 2008 through July 17, 2008. The survey was initiated using the fundamental survey process. A random sample of two clients was selected from a resident population of four men with various disabilities. In addition, a focused review was conducted of a third client's active treatment (day placement) and staffing (one-on-one) needs. The findings of the survey were based on observations, interviews with clients and staff in the home and at two day programs, as well as a review of client and administrative records, including incident reports.	W 000	Received 8/11/08 GOVERNMENT OF THE DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH HEALTH REGULATION ADMINISTRATION 825 NORTH CAPITOL ST., N.E., 2ND FLOOR WASHINGTON, D.C. 20002	
W 104	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the governing body exercised general policy and operational direction over the facility, except in the following areas. The findings include: 1. Cross-refer to W153 and W154. The governing body failed to ensure that unusual incidents, such as abrasions of unknown etiology and rectal bleeding, were reported and investigated in accordance with facility policies. 2. Cross-refer to W159.6. The governing body failed to ensure that the facility established an effective means to obtain accurate body weights for Client #2.	W 104	Refer to W 153 & PP. 6 &7 Individual #2 is being weighed at the same time of the day with the similar amount of clothing to ensure accuracy of his body weight. He is currently being weighed on a chair scale. In the future, the nursing staff &Qmrp will ensure that client #2 is weighed accurately.	8-08-08

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Michele Fenwick TITLE Program Director (X6) DATE 8-11-08

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 104	Continued From page 1 3. Cross-refer to W331. The governing body failed to ensure that the facility's medical team established a means of ensuring that Client #1's Diastat medication was administered in accordance with physician's orders, or that a suitable alternative treatment plan was secured from the neurologist and primary care physician.	W 104	The diastat was ordered by the neurologist to administer to client # for seizures that lasted three minutes or longer, and then to transport him to the ER; however, the facility failed to provide the medication to the day program. The nurse coordinator contacted the PCP, who in return contacted the Neurologist. The Neurologist has discontinued the diastat. Refer to attach # 1 In the future, the nursing staff and Qmrp will ensure that the the day program is provided with the PRN medication, and that the alternate treatment plan was secured. The alternative treatmentplan was to send client #3 to the ER which was implemented by the facility.	7-29-08
W 112	483.410(c)(2) CLIENT RECORDS The facility must keep confidential all information contained in the clients' records, regardless of the form or storage method of the records. This STANDARD is not met as evidenced by: Based on observation, the facility failed to ensure the confidentiality of personal information, for four of the four residents of the facility (and all other individuals served by the agency). The findings include: 1. On July 15, 2008, at approximately 6:45 AM, a diet chart was observed posted openly on the refrigerator door in the kitchen. It listed the specialized, prescribed diets for all four of the residents, including Client #4's mealtime protocol that addressed reflux, regurgitation and other dietary concerns. 2. On July 15, 2008, at approximately 8:00 AM, review of the Medication Administration Record (MAR) book following observation of the morning medication pass revealed that it included a listing of all individuals receiving residential services through RCM of Washington. The list showed the full names, social security numbers, dates of birth and other personal information for residents of all	W 112	All diet orders were removed from the front of the refrigirator. In the future, the facility will ensure that the individuals' information are kept confidentially or unconspiciously. Refer to attachment #2 All the individuals' personal information were removed from the front the MAR. In the future, the facility will ensure that the individuals' information are kept confidentially.	7-17-08 7-17-08

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W 112	Continued From page 2 group homes and supervised apartment settings.	W 112		
W 120	483.410(d)(3) SERVICES PROVIDED WITH OUTSIDE SOURCES The facility must assure that outside services meet the needs of each client. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that outside services met the needs of one of two clients in the sample. (Client #2) The finding includes: The dental provider failed to ensure that the group home was updated on the status of Client #2's halitosis and periodontitis during his visits for scaling and prophylaxis, as follows: Observation of Client #2 on July 15, 2008, at 7:22 AM, when he smiled revealed he had crowded teeth. Interview with day program staff later that day, at approximately 12:40 PM, indicated their concern that he had bad breath. They also were concerned that his gums sometimes bled, especially when he bit hard objects. Day program staff stated that the client had a behavior support plan,dated November 2007, which included a goal to his decrease incidents of sucking or chewing on inanimate objects. Further interview revealed that they thought the client had recently been to the dentist. However, there had been no request to date for assisting him with toothbrushing while at the day program. Record review on July 16, 2008 revealed the client had a history of periodontitis, halitosis and	W 120	It is the responsibility of the agency to ensure the coordination of the outside services rendered to the individuals. The Qmrp has contacted the day program coordinator to implement the teeth brushing goal to assist client # 2 with toothbrushing while at the day program. Furthermore,the nurse coordinator will attach a copy of the previous dental consult for the dentist to review prior to the examination. In the future, the nursing staff, and Qmrp will ensure that the dentist provides the home with current status of individual #2 diagnosed halitosis and periodontitis in writing.	8-12-08

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W 120	Continued From page 3 large deposits of calculus and plaque on his teeth. On June 27, 2007, for example, the dentist noted "Findings: F/u: generalized scaling, prophylaxis with polish. Recommendation: brush teeth 2 - 3 times daily. Return appointment (6 months)." A dental consultation report dated June 4, 2008 revealed "Finding: full mouth scaling, adult prophylaxis and polishing. Recommendation: Brush teeth 2 - 3 times a day. F/U in 6 months." Aside from documenting treatment rendered, the dentist failed to provide the group home with written findings on the status of Client #1's diagnosed halitosis and periodontitis. In addition, there was no evidence that the dentist advised the group home regarding the effectiveness of the client's dental hygiene program.	W 120	It is the responsibility of the agency to ensure the coordination of the outside services rendered to the individuals. The Qmrp has contacted the day program coordinator to implement the tooth brushing goal to assist client # 2 with toothbrushing while at the day program. 8-12-08 Furthermore,the nurse coordinator will attach a copy of the previous dental consult for the dentist to review prior to the examination. 8-08-08 In the future, the nursing staff, and Qmrp will ensure that the dentist provides the home with the current status of individual #2 diagnosed halitosis and periodontitis in writing.	
W 149	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. This STANDARD is not met as evidenced by: Facility staff failed to consistently implement the facility's incident management policies. The findings include: 1. Cross-refer to W153.1. There was no evidence that an abrasion/ reddened area discovered on the left side of Client #1's forehead on April 14, 2008 was reported and investigated in accordance with facility policies. 2. Cross-refer to W153.2. There was no	W 149	Refer to W 153.1 P.5	8-01-08

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W 149	Continued From page 4 evidence that a February 7, 2008 incident wherein Client #1's day program staff observed blood in the toilet was reported and investigated in accordance with facility policies.	W 149	Client # 1 was evaluated by the facility nurse based on the day program report of blood in stool, but no blood was present when he had bowel movement at home. To prevent re-occurance of this type of miscommunication, the nursing staff will follow-up on all reports or incidents from the day program to ensure that appropriate medical intervention is implemented. All incidents from the day program will be reported and investigated in accordance with facility policies. There will be a communication log between the day program and the facility to ensure that daily occurances are documented. The Qmrp will have a dialogue with the nurse during the site observations. In the future All incidents from the day program will be reported, and investigated in accordance with facility policies.	
W 153	483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. This STANDARD is not met as evidenced by: Based on interview, review of incident reports and review of client records, the facility failed to ensure that all injuries of unknown origin were consistently reported immediately to the administrator and to the State agency. The findings include: 1. On July 17, 2008, at 3:45 PM, review of Client #1's Nurse Progress Notes in the residence revealed the following: "April 14, 2008, 7 AM - Reddened spot on left side of forehead. No open area noted." "April 14, 2008, 7 PM - Abrasion on left side of forehead cleaned with normal saline solution and antibiotic ointment applied. No noted drainage." "April 15, 2008, 7:40 PM - Reddened area on left side of forehead cleaned with normal saline solution and antibiotic ointment applied. No drainage present." "April 16, 2008, 1:25 PM - Seen today by <PCP>... forehead 1 cm by 1 cm erythematous..." Further review of Client #1's record and	W 153	All injuries of unknown origin must be documented, and investigated according to the incident management policies. The facility failed to document the indident of the reddened spot on the left side of forehead on 4-14-08 The staff were inserviced on the incident reporting and documentation refer to attachment # 3 In the future, the facility will ensure that all of the incidents of unknown origin are immediately reported to the agency administrator, and state agency, documented, and investigated according to the incident management policy. In the future All incidents from the day program will be reported and investigated in accordance with facility policies.	8-01-08

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W 153	Continued From page 5 interviews with the LPN Coordinator and Qualified Mental Retardation Professional (QMRP) revealed no evidence that this injury of the reddened area had been reported to the facility's administrator or to the State agency in accordance with agency policies. 2. On July 15, 2008, at 1:28 PM, Client #1's day program Activities Coordinator was asked if the client had experienced any unusual incidents or injuries. He directed this surveyor to the appropriate section of the client's record. On February 7, 2008, the day program nurse documented on a Further Evaluation Report (FER) form that blood was seen in the toilet after Client #1 had used it. He was then assessed by the nurse "and blood was noted in his rectal area. Could not see whether or not he has hemorrhoids. Please re-evaluate and treat accordingly." On July 17, 2008, at 4:00 PM, review of Client #1's nurse progress notes in the residence revealed the following entry, dated February 7, 2008: "Note from day program stating blood... continue to be monitored for blood in stool. Designated nurse was made aware." A February 8, 2008, 7:00 AM nurse progress note indicated "BM last night, no blood." At 4:50 PM, the LPN Coordinator/ Designated Nurse was asked about the bloody stool. She stated that day program staff had discovered blood in the commode; however, they had not been sure that it had come from Client #1. She further stated that there had been no blood observed in his clothing. When this surveyor read a direct quote taken from the FER, in which the day program nurse wrote having seen blood "in	W 153	Client # 1 was evaluated by the facility nurse based on the day program report of blood in stool, but no blood was present when he had bowel movement at home. To prevent the occurance of this type of miscommunication, the nursing staff will follow-up on all reports or incidents that are reported by the day program to ensure that appropriate medical attention is implemented. All incidents from the day program will be reported, and investigated in accordance with the facility policies. There will be a communication log between the day program and the facility to ensure that daily occurances are documented. The Qmrp will have a dialogue with the nurse during the site observations. In the future All incidents from the day program will be reported, and investigated in accordance with facility policies.	

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W 153	Continued From page 6 his rectal area," the LPN Coordinator denied having seen the FER. The immediate-past QMRP was present at the time. She indicated that she had not been informed of a bloody stool. She further indicated that she had visited the day program on February 11, 2008 (4 days after the incident) and the bloody stool had not been brought to her attention. The QMRP and LPN Coordinator both acknowledged that Client #1's bleeding episode had not been reported to their administrator or to the State agency, as it had not been perceived by the facility as an injury of unknown origin.	W 153	Client # 1 was evaluated by the facility nurse based on the day program report of blood in stool, but no blood was present when he had bowel movement at home. To prevent the re-occurance of this type of miscommunication, the nursing staff will follow-up on all of the reports or incidents that are reported by the day program to ensure that appropriate medical attention is implemented. All incidents from the day program will be reported, and investigated in accordance with facility policies. There will be a communication log between the day program and the facility to ensure that daily occurances are documented. The Qmrp will have a dialogue with the nurse during the site observations In the future All incidents from the day program will be reported, and investigated in accordance with the facility policies.	
W 154	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to document that all potential injuries of unknown origin were thoroughly investigated. The findings include: Cross-refer to W153.2. On February 7, 2008, Client #1's day program staff observed blood in the toilet. He was assessed by the day program nurse and a note was sent home. On July 17, 2008, review of Client #1's records in the residence as well as onsite interviews with the QMRP and LPN Coordinator revealed that the home had been aware of the bleeding episode. There was no evidence, however, that the cause of the bleeding had been investigated.	W 154	Client # 1 was evaluated by the facility nurse based on the day program report of blood in stool, but no blood was present when he had bowel movement at home. To prevent the re-occurance of this type of miscommunication, the nursing staff will follow-up on all of the reports or incidents that are reported by the day program to ensure that appropriate medical attention is implemented. All incidents from the day program will be reported, and investigated in accordance with facility policies. There will be a communication log between the day program and the facility to ensure that daily occurances are documented. The Qmrp will have a dialogue with the nurse during the site observations In the future All incidents from the day program will be reported, and investigated in accordance with the facility policies.	

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W 154	Continued From page 7 This is a repeat deficiency. See Federal Deficiency Report dated August 23, 2007.	W 154		
W 159	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. This STANDARD is not met as evidenced by: Based on observation, staff interview and record verification, the Qualified Mental Retardation Professional (QMRP) failed to coordinate and monitor services for two of the two clients in the sample. (Clients #1 and #2) The findings include: 1. Cross-refer with W120. The QMRP failed to obtain periodic status of Client #2's diagnosed halitosis and periodontitis. 2. Cross-refer to W153 and W154. The QMRP failed to ensure that unusual incidents, such as abrasions of unknown etiology and rectal bleeding, were reported and investigated in accordance with facility policies. 3. Cross-refer to W247. The QMRP failed to ensure that Client #1's plan provided sufficient guidance to staff on the use of his safety helmet. He was not observed wearing the helmet while in the facility. His physician's orders, however, and other components of his plan did not reflect client choice. 4. Cross-refer to W262. The QMRP failed to ensure that the facility's Human Rights	W 159	Refer to W 120 PP 3 & 4 Refer to W 153 & 154 PP , 6 & 7 The helmet protocol was developed by the PT which indicates when client #3 should wear, or remove his helmet. Once approved by the HRC, the physician order and other components will reflect client #3 choice. Refer to attachment # 4	8-08-08 8-04-08

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W 159	Continued From page 8 Committee (HRC) addressed Client #1's right to refuse to wear his safety helmet when he was hot or uncomfortable. 5. Cross-refer to W331.1. The QMRP failed to monitor and coordinate Client #1's seizure protocol with the facility's medical team. 6. The QMRP failed to collaborate with the nursing team to ensure accurate weight measurements were obtained for Client #2, in accordance with physician's orders, as follows: On July 15, 2008, at approximately 7:02 AM, the medication nurse gave Client #2 a can of Carnation Instant Breakfast. She stated that the supplement was prescribed to encourage weight gain. He drank the supplement quickly and observation that day showed that he ate 100% of his breakfast, lunch, afternoon snack (doubled) and dinner. When interviewed on July 16, 2008, the LPN Coordinator stated that the client had refused to stand still long enough to obtain an accurate reading on bathroom scales. They had since replaced the bathroom scale with a chair scale. However, Client #2 moved continuously while seated in the new chair scale, still making it difficult to obtain an accurate reading. The LPN Coordinator stated that she was not sure how they might encourage the client to remain still while his weight was being assessed. . Although record review revealed the client was prescribed to be weighed weekly, there were possible issues regarding accuracy of the client's weights. On July 17, 2008, Client #2's nutritional records were reviewed, beginning at approximately 1:00 PM. A July 2007 annual Nutritional Assessment indicated that the client	W 159	The helmet protocol will be presented to the HRC on 8-18-08; The committee will address client # 3 right to refuse to wear his safety helmet when he is hot or uncomfortable, and will beincorporated in his plan of care. Refer to W 104 Refer to W 331.1 P. 17 The Qmrp will collaborate with the nursing staff by ensuring that client # 2 is weighed with the same amount of clothing in order to obtain his accurate weight. In the future the Qmrp will ensure that appropriate measures are in place in order to obtain client #2 accurate weight. The Qmrp will collaborate with the nursing staff by ensuring that client # 2 is weighed with the same amount of clothing in order to obtain the accurate weight. In the future the Qmrp will ensure that appropriate measures are in place in order to obtain client #2 accurate weight.	8-18-08 7-29-08 8-08-08

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W 159	Continued From page 9 weighed 114 pounds in June 2007. His ideal weight range was cited as 92 - 112 pounds, with optimal weight of 102 pounds. Review of the nutritionist's quarterly reports, dated October 19, 2007, January 19, 2008 and April 21, 2008, documented the facility's ongoing difficulty in accurately assessing the client's weight. The same concern was identified in the most recent annual Nutritional Assessment, dated June 28, 2008. Review of Client #2's weight chart revealed that the weights being recorded weekly had fluctuated widely during the past year, between 84 - 102 pounds. For example, a weight of 97 pounds was recorded the first week of September 2007. It had dropped to 84 pounds the very next week, then up to 90 pounds in week 3 and another drop to 86 pounds in the final week. Weights recorded in more recent months showed a steady drop from 102 pounds the first week of March 2008 to 90 pounds in the first week of May 2008. There was no evidence that the QMRP sought input from the primary care physician and/or the interdisciplinary team regarding strategies to accurately assess Client #2's weight. Without accurate readings, the medical team could not determine his specific caloric needs for weight maintenance or weight gain. It should be noted that Client #2's 91-pound average weekly weight in June and July 2008 was below his ideal weight range. It should be further noted that Client #2's annual Nutritional Assessment, dated June 28, 2008, indicated that he was at 'moderate to low nutritional risk' due to the number of medications	W 159	The Qmrp will collaborate with the nursing staff by ensuring that client # 2 is weighed with the same amount of clothing in order to obtain the accurate weight. In the future the Qmrp will ensure that appropriate measures are in place in order to obtain client #2 accurate weight. Individual #2 is being weighted at the same of the day with similar amount of clothing to ensure the accuracy of his body weight. He is currently weighed a chair scale. In the future, the nursing staff & Qmrpf will ensure that client #2 is weighed with the same amount of clothing in order to obtain his accurate weight. The Qmrp will collaborate with the nursing staff by ensuring that client # 2 is weighed with the same amount of clothing in order to obtain the accuracy of the weight. 8-08-08 In the future the Qmrp will ensure that appropriate measures are in place in order to obtain client #2 accurate weight.	8-08-08 8-08-08

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	09G178	A. BUILDING _____ B. WING _____	07/17/2008

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W 159	Continued From page 10 he received daily.	W 159		
W 247	483.440(c)(6)(vi) INDIVIDUAL PROGRAM PLAN The individual program plan must include opportunities for client choice and self-management. This STANDARD is not met as evidenced by: Based on observation, staff interview, and record review, the facility failed to ensure that individual program plans reflected choice and self-management, for one of the two clients in the sample. (Client #1) The findings include: Client #1's individual plan failed to specify when his prescribed safety helmet must be worn and how the facility might accommodate his perceived choice to remove the helmet, as follows: 1. On July 15, 2008, at 6:30 AM, Client #1 was observed seated on the edge of his bed. He was alone at that time, rocking forward and backward and was not wearing a safety helmet. At approximately 6:45 AM, a direct support staff person was observed leading the client into the living room, still without a safety helmet. At 7:05 AM, staff led him into the dining room and he sat at the table to receive his medications. No safety helmet was observed then, or in the period that followed, while he ate his breakfast. Later that day, Client #1 was again observed not wearing his safety helmet while in the facility, between 3:53 PM - 5:38 PM. Similar observations were made on the next 2 days of the survey. On July 15, 2008, at approximately 8:20 AM,	W 247	The helmet protocol was developed by the PT which indicates when client #3 should wear, or remove his helmet. Once approved by the HRC, the physician order and other components will reflect client #3 choice. Refer to attachment #4 In the future, the Qmrp will ensure that client #3 written plan includes all of the specific guidelines.	8-04-08

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W 247	Continued From page 11 review of Client #1's July 2008 physician's orders (POs) revealed the following "helmet - safety for seizure precautions." During the entrance conference beginning at approximately 10:45 AM, the immediate-past Qualified Mental Retardation Professional (QMRP) stated that the helmet should be worn at all times due to the client's seizure disorder as well as self-injurious behaviors. When asked if that included while he was seated in his padded rocker/ recliner chair in the living room, she replied yes... to ensure his safety if he were to fall to the side. Client #1's records were reviewed, beginning at 8:23 AM on July 16, 2008. His written plan failed to provide clear guidelines/ instructions regarding when he must wear the helmet and when he might be allowed to remove it safely, as follows: 2. Client #1's draft Individual Support Plan (ISP), dated May 9, 2008, included the following recommendations: "Behavior... Adhere to the medical recommendations for the use of the helmet." "Mobility... Continue to wear helmet. Follow BSP." "Health... Continue to offer the helmet as prescribed to protect from head injuries from falls and seizures." The ISP, did not, however, offer more specific guidelines. 3. Client #1's Health Management Care Plan, dated July 15, 2008, made no mention of his use of a safety helmet. 4. At 12:20 PM, Client #1's Behavior Support Plan (BSP), dated May 2008, reflected target self-injurious behaviors such as "hitting his head against hard surface" and "use of the helmet has	W 247	The helmet protocol was developed by the PT which indicates when client #3 should wear, or remove his helmet. Once approved by the HRC, the physician order and other components will reflect client #3 choice. Refer to attachment #4 In the future, the Qmrp will ensure that client #3 written plan includes all of the specific guidelines. The helmet protocol was developed by the PT which indicates when client #3 should wear, or remove his helmet. Once approved by the HRC, the physician order and other components will reflect client #3 choice. Refer to attachment #4 In the future, the Qmrp will ensure that client #3 written plan includes all of the specific guidelines. Client #3 Health Management Care Plan was updated to include the use of the safety helmet Refer to attachment #5 In the future the DON will ensure that client #3 HMCP includes all of the area of risks and safety.	8-04-08 8-04-08 8-06-08

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W 247	Continued From page 12 been medically ordered. Its use should follow the protocol identified by that team and/or PT... tends to remove it when he seems hot and uncomfortable. He should wear it, however, when traveling as if seizure activity occurs, or after it, he may hit his head on windows, etc." There was no helmet protocol observed and no further instructions regarding if/ how staff were to accommodate the client's wish to remove the helmet when hot or uncomfortable. [Note: The BSP and ISP both incorporated the use of one-on-one staff assistance, for safety. Observations throughout the survey revealed this component of the plan being implemented.] 5. Client #1's physical therapy assessments, dated April 23, 2007 and May 9, 2008, included "continue to wear helmet, follow BSP." The PT assessments did not specify when he should wear the helmet and when he might be allowed to remove it safely. 6. On July 17, 2008, at approximately 5:00 PM, interview with the QMRP appointed in May 2008 revealed that staff "encourage" Client #1 to wear his helmet but will not force him to put it back on if he removes it and does not want to wear it. Staff, however, were not observed offering the client encouragement to put on his helmet while in the facility at any time during the survey observation periods. Further interview with the QMRP confirmed that there was no written protocol to specify how or when staff could safely accommodate his wishes. It should be noted that on July 17, 2008, further interview with the immediate-past QMRP and review of Human Rights Committee (HRC) minutes revealed that the helmet was discussed	W 247	The helmet protocol was developed by the PT which indicates when client #3 should wear, or remove his helmet. Once approved by the HRC, the physician order and other components will reflect client #3 choice. Refer to attachment #4 In the future, the Qmrp will ensure that client #3 written plan includes all of the specific guidelines. The helmet protocol was developed by the PT which indicates when client #3 should wear, or remove his helmet. Once approved by the HRC, the physician order and other components will reflect client #3 choice. Refer to attachment #4 In the future, the Qmrp will ensure that client #3 written plan includes all of the specific guidelines. The helmet protocol was developed by the PT which indicates when client #3 should wear, or remove his helmet. Once approved by the HRC, the physician order and other components will reflect client #3 choice. Refer to attachment #4 In the future, the Qmrp will ensure that client #3 written plan includes all of the specific guidelines.	8-04-08 8-04-08 8-04-08

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W 247	Continued From page 13 as a restrictive component of Client #1's BSP and "for safety (unsteady gait and falling)." The HRC had not, however, discussed how staff should balance the client's right to refuse to wear it versus his right to be protected from potential injury.	W 247	The helmet protocol will be presented to the HRC on 8-18-08; The committee will address client # 3 right to refuse to wear his safety helmet when he is hot or uncomfortable.	8-18-08
W 262	483.440(f)(3)(i) PROGRAM MONITORING & CHANGE The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility's Human Rights Committee (HRC) failed to discuss how staff should balance Client #1's right to refuse to wear a prescribed safety helmet with his right to be protected from potential injury. The findings include: Cross-refer to W247. Client #1 was prescribed a safety helmet due to seizure activity, an unsteady gait with risk of falls and his self-injurious behavior of hitting his head against walls, floors and other hard surfaces. His July 2008 physician's orders (POs) revealed the following "helmet - safety for seizure precautions." The orders did not indicate times when he might be allowed to remove the helmet. His Individual Support Plan (ISP), dated May 9, 2008, reflected the use of a safety helmet. The ISP did not, however, indicate when he should wear it or whether there were times when he could safely	W 262	The helmet protocol was developed by the PT which indicates when client #3 should wear, or remove his helmet. Once approved by the HRC, the physician order and other components will reflect client #3 choice. Refer to attachment #4 In the future, the Qmrp will ensure that client #3 written plan includes all of the specific guidelines.	8-04-08

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W 262	Continued From page 14 go without wearing it. The recently-appointed QMRP said that staff"encourage" Client #1 to wear his helmet but will not force him to put it back on if he removes it and does not want to wear it. Staff, however, were not observed offering the client encouragement to put on his helmet while in the facility at any time during the survey observation periods, and he did not wear it while at home. Further interview with the QMRP confirmed that there was no written protocol to specify how or when staff could safely accommodate his wishes. On July 17, 2008, at 5:05 PM, interview with the immediate-past QMRP revealed that the HRC had not discussed how staff should balance the client's right to refuse to wear the helmet versus his right to be protected from potential injury. Moments later, at 5:15 PM, review of the HRC minutes dated May 12, 2008 revealed that the helmet had been approved as a restrictive component of Client #1's BSP and "for safety (unsteady gait and falling)." The HRC minutes did not, however, reflect any discussion regarding how the facility might honor the client's alleged wish to remove his helmet at times. The immediate-past QMRP signed the attendance for that HRC meeting.	W 262	The helmet protocol was developed by the PT which indicates when client #3 should wear, or remove his helmet. Once approved by the HRC, the physician order and other components will reflect client #3 choice. Refer to attachment #4 In the future, the Qmrp will ensure that client #3 written plan includes all of the specific guidelines.	8-04-08
W 322	483.460(a)(3) PHYSICIAN SERVICES The facility must provide or obtain preventive and general medical care. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide preventive and	W 322		

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W 322	Continued From page 15 general medical care for one of the two clients in the sample. (Client #1) The finding includes: Cross-refer to W331.1. The facility's medical team failed to develop and implement a plan to ensure that Client #1's Diastat medication was administered in accordance with physician's orders (POs). Client #1's POs also reflected the following: "Diastat 15 mg Acudial, Insert 1 syringe (15 mg) for seizures lasting more than 3 minutes. Patient to go to ER via 911." During the past 12 months, there had been 3 separate dates on which Client #1 experienced prolonged seizures (lasting more than 3 minutes). Each time, Client #1 was taken to the ER; however, Diastat was not administered on any of those 3 dates. On July 17, 2008, beginning at 11:34 AM, the LPN Coordinator and the RN/Director of Nursing were interviewed in the facility. The Diastat cartridge and syringe were locked in the medication cabinet. The medication was secured under lock and key at all times, with keys held only by nursing staff. They acknowledged that the medication was not accessible immediately should Client #1 experience a seizure when there was no nurse present in the facility. In addition, the facility failed to ensure that a Diastat syringe was available for use at the day program. Review of the client's primary care physician (PCP) notes failed to show evidence that this topic had been identified as a concern, prior to the survey. In addition, there was no documented evidence that the medical team had addressed the concern with the neurologist, to determine whether an alternate medication might be	W 322	Client # 3 diastat was not administrated due to the location of his seizure activities; the nursing staff was not in the facility; however, the facility has a seizure protocol to transort the individual to the ER, and activate 911 if necessary for prolonged seizures than 3 minutes or longer. The neurologist was contacted regarding possible alternative medication since seizures can not be predicted, and client #3 home is not a 24hrs nursing facility. The neurologist stated to take him to the ER for evaluation; The diastat order was discontinued by the PCP after consulting with the neurologist. Refer to attachment # 1 Client # 3 diastat was not administrated due to the location of his seizure activities; the nursing staff was not in the facility; however, the facility has a seizure protocol to transort the individual to the ER, and activate 911 if necessary for prolonged seizures than 3 minutes or longer. The neurologist was contacted regarding possible alternative medication since seizures can not be predicted, and client #3 home is not a 24hrs nursing facility. The neurologist stated to take him to the ER for evaluation; The diastat order was discontinued by the PCP after consulting with the neurologist. Refer to attachment # 1	7-29-08 7-29-08

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W 322	Continued From page 16 Indicated. The nurses confirmed this during the July 17, 2008 interview. At the time of the survey, the facility was unable to ensure that Client #1 received the Diastat immediately during a prolonged seizure, in accordance with his orders.	W 322		
W 331	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure nursing services in accordance with the needs of two of the two clients in the sample. (Clients #1 and #2) The findings include: 1. On July 15, 2008, the morning medication pass was observed, beginning at 6:57 AM. Client #1 received his medications at 7:10 AM. Depakote, Topamax and Keppra were among the medications he received. The medication nurse indicated that these medications (plus Tegretol in the evening) were for the control of seizures. This was verified afterwards, at 8:15 AM, by review of the client's July 2008 physician's orders (POs). Client #1's POs also reflected the following: "Diastat 15 mg Acudial, Insert 1 syringe (15 mg) for seizures lasting more than 3 minutes. Patient to go to ER via 911." On July 16, 2008, Client #1's neurology and seizure records were reviewed, beginning at 4:45	W 331	Refer to w 332 P.16	7-29-08

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W 331	Continued From page 17 PM. His seizure protocol (not dated) reflected the order for Diastat and calling 911 for seizures lasting more than 3 minutes. Further review of the client's chart, however, revealed a repeated failure to administer a Diastat injection following seizure activity, as follows: a. The client was hospitalized on November 29, 2007 after experiencing multiple (5) seizures, including: 4 minutes at 10:06 AM and 4 minutes at 11:30 AM. Review of the client's Medication Administration Record (MAR) for November 2007 and relevant incident and investigation reports failed to show evidence that Diastat was administered. [Note: Diastat was first ordered, at 10 mg, beginning on January 24, 2007.] b. Previously, Client #1 had experienced a 3-minute seizure on September 4, 2007. At that time, the client was not administered Diastat. The neurologist wrote a note to the facility on the corresponding consultation report, on the same date, reminding nurses that he was to receive Diastat. c. The client was again hospitalized on February 13, 2008 after experiencing multiple seizures: 4 minutes at 9:02 AM and 5 minutes at 12:18 PM. Review of the client's Medication Administration Record (MAR) for February 2008 and relevant incident reports and investigations failed to show evidence that Diastat was administered. On that same day, the dose of Diastat was increased from 10 mg to 15 mg after he experienced these seizures.	W 331	Refer to W 332 P.16 Refer to W 332 P.16 Client #3 seizures occured at different locations; for instance,he had seizures in route to his day program, at the PCP's office, and at the ER; he spent the night at the hospital, and he had no further seizures per discharge report.	7-29-08 7-29-08

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W 331	Continued From page 18 d. On July 17, 2008, beginning at 10:16 AM, review of Client #1's primary care physician (PCP) notes revealed no evidence that nurses informed the PCP that the client had not been administered Diastat as ordered, on the 3 seizure events referenced above. e. On July 17, 2008, review of Client #1's nursing records failed to show documented evidence that the nursing team had discussed the repeated failure to administer Diastat in accordance with POs. f. On July 17, 2008, beginning at 11:34 AM, the LPN Coordinator and the RN/Director of Nursing were interviewed in the facility. The Diastat cartridge and syringe were locked in the medication cabinet. The LPN Coordinator stated that they remained secured under lock and key at all times, with keys held only by nursing staff. 1) The LPN Coordinator unlocked the cabinet and presented the Diastat cartridge and syringe. She acknowledged that the medication was not accessible immediately should Client #1 experience a seizure when there was no nurse present in the facility. 2) The LPN Coordinator indicated that the facility was unable to ensure that a nurse could arrive within minutes of Client #1 experiencing a seizure that lasted over 3 minutes. 3) The LPN Coordinator confirmed that on the 3 dates listed above, Client #1 did not receive the Diastat injection as ordered. 4) The LPN Coordinator and the RN/Director of Nursing stated that they had discussed this issue	W 331	Client # 3 PCP was aware that he did not receive diastat during his seizure activities because he was in route to his day program; he had seizures at her office as well. The PCP contacted the neurologist who recommended to take client # 3 to the ER for evaluation. Currently the diastat order was discontinued. 7-29-08 Refer to W 332 P.16 7-29-08 Client # 3 diastat was not administrated due to the location of his seizure activities; the nursing staff was not in the facility; however, the facility has a seizure protocol to transport the individual to the ER, and activate 911 if necessary for prolonged seizures than 3 minutes or longer. The neurologist was contacted regarding possible alternative medication since seizures can not be predicted, and client #3 home is not a 24hrs nursing facility. The neurologist stated to take him to the ER for evaluation; The diastat order was discontinued by the PCP after consulting with the neurologist. 7-29-08 Refer to attachment # 1 Refer to W 331 (d) P.19 7-29-08 The diastat can only be administrated by a nurse; hense it was safely locked in the cabinet Client # 3 did not receive diastat during his seizure activities because he was in route to his day program; he had seizures at the PCP office; the PCP contacted the neurologist who recommended to take client # 3 to the ER for evaluation. Currently the diastat has been discontinued. 7-29-08	

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W 331	Continued From page 19 among themselves, then acknowledged that they had not brought up the topic with the PCP. 5) The LPN Coordinator and the RN/Director of Nursing also acknowledged that they had not discussed the topic with the neurologist. 6) When asked if the medication was available at Client #1's day program, the LPN Coordinator and the RN/Director of Nursing both stated that they had not checked with the day program. They added, however, that neither had delivered the medication to the day program themselves. 7) Client #1's day program was contacted by telephone on July 17, 2008, at 12:10 PM. The day program RN indicated that the topic had been discussed "a long time" earlier. During the telephone call, she looked in their medication supply and reported having found no evidence of a Diastat cartridge with syringe. She then stated "they didn't bring it." Facility nurses failed to establish a means of ensuring that Client #1's Diastat medication could be administered in accordance with physician's orders. 2. Cross-refer to W153.2. On February 7, 2008, Client #1's day program reported blood in the toilet after Client #1 had used it. The day program nurse assessed him and sent a note home reporting: "and blood was noted in his rectal area. Could not see whether or not he has hemorrhoids. Please re-evaluate and treat accordingly." On July 17, 2008, at 4:00 PM, review of Client #1's nurse progress notes in the residence	W 331	Client # 3 PCP was aware that he did not receive diastat during his seizure activities because he was in route to his day program; he had seizures at her office as well. The PCP contacted the neurologist who recommended to take client # 3 to the ER for evaluation. Currently the diastat order has been discontinued. The neurologist was contacted on 7-15-08 regarding the diastat order that has not been administered due to the location of the seizures activities that lasted 3 minutes or more. The neurologist responded to send client # 3 to the ER when there is no nurse to administer the diastat. Client #3 day program never discussed his diastat order with his home nurse; however, in the future, the facility nurse will ensure that PRN medications are available to the day program. Client # 1 was evaluated by the facility nurse based on the day program report of blood in stool, but no blood was present when he had bowel movement at home. To prevent the re-occurance of miscommunication, the nursing staff will follow-up on all incidents reported by the day program to ensure that appropriate medical intervention is implemented. All incidents from the day program will be reported, and investigated in accordance with facility policies. There will be a communication log between the day program and the facility to ensure that daily occurances are documented. The Qmrp will have a dialogue with the nurse during the site observations In the future All incidents from the day program will be reported, and investigated in accordance with the facility policies.	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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	09G178	A. BUILDING _____ B. WING _____	07/17/2008

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W 331	Continued From page 20 revealed the following entry, dated February 7, 2008: "Note from day program stating blood... continue to be monitored for blood in stool. Designated nurse was made aware." A February 8, 2008, 7:00 AM nurse progress note indicated "BM last night, no blood." On July 17, 2008, at 4:50 PM, the LPN Coordinator/ Designated Nurse was asked about the bloody stool. She stated that day program staff had discovered blood in the commode; however, the day program could not verify that it had come from Client #1. She further stated that there had been no blood observed in his clothing. When this surveyor read a direct quote taken from the Further Evaluation Report form, in which the day program nurse wrote having seen blood "in his rectal area," the LPN Coordinator denied having seen the document. Further interview and review of the client's nursing notes failed to show evidence that a residential nurse had re-assessed him to determine possible cause(s) of the bleeding. 3. Cross-refer to W356.2. Client #2 had a history of periodontitis, halitosis. A February 4, 2008 dental consultation report revealed "Large deposits of plaque and calculus present on all teeth surfaces. Gingival margins inflamed. Halitosis Periodontitis". On July 17, 2008, interview with the LPN Coordinator revealed that she intermittently monitored the frequency of Client #2's gum bleeding during tooth brushing to determine the effectiveness of his dental hygiene program. Further interview with the nurse indicated that the client had a toothbrushing objective which was being monitored by the QMRP.	W 331	Client # 1 was evaluated by the facility nurse based on the day program report of blood in stool, but no blood was present when he had bowel movement at home. To prevent the re-occurance of miscommunication, the nursing staff will follow-up on all incidents reported by the day program to ensure that appropriate medical intervention is implemented. All incidents from the day program will be reported, and investigated in accordance with facility policies. There will be a communication log between the day program and the facility to ensure that daily occurances are documented. The Qmrp will have a dialogue with the nurse during the site observations In the future All incidents from the day program will be reported, and investigated in accordance with the facility policies. It is the responsibility of the agency to ensure the coordination of the outside services rendered to the individuals. The Qmrp has contacted the day program coordinator to implement the brushing goal I to assist client # 2 with topthbrushing while at the day program. 8-12-08 Furthermore, the nurse coordinator will attach a copy of the previous dental consult for the dentist to review prior to the examination. 8-08-08 In the future, the nursing staff, and Qmrp will ensure that the dentist provides the home with the current status of individual #2 diagnosed halitosis and periodontitis in writing, and that there is a continuation of services between the day program and the residence.	

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W 331	Continued From page 21 The nurse acknowledged, however, that during the treatment visits, the dentist had not provided information concerning the status of the client's dental hygiene. She further acknowledged that the facility had not sought additional information regarding the status of the periodontitis and halitosis. In addition, even though the dentist's findings in February 2008 indicated that his oral hygiene had worsened, facility nurses failed to address the need.	W 331		
W 356	483.460(g)(2) COMPREHENSIVE DENTAL TREATMENT The facility must ensure comprehensive dental treatment services that include dental care needed for relief of pain and infections, restoration of teeth, and maintenance of dental health. This STANDARD is not met as evidenced by: Surveyor: Torbit, Marcella Based on observation, interview and record review, the facility failed to ensure comprehensive treatment services for the maintenance of dental health, for two of the two clients in the sample. (Clients #1 and #2) The findings include: 1. Cross-refer to W120. The facility failed to obtain updated information on the status of Client #2's diagnosed halitosis and periodontitis. The dentist's written documentation on June 26, 2007 and June 4, 2008 reflected only the treatments rendered (scaling and prophylaxis). 2. The facility failed to consistently implement the dentist's recommendations to promote Client #2's	W 356	It is the responsibility of the agency to ensure the coordination of the outside services rendered to the individuals. The Qmrp has contacted the day program coordinator for the implementation of the brushing goal to assist client # 2 with toothbrushing while at the day program. 8-12-08 Furthermore,the nurse coordinator will attach a copy of the previous dental consult for the dentist to review prior to the examination. 8-08-08 In the future, the nursing staff, and Qmrp will ensure that the dentist provides the home with the written findings of the status of individual #2 diagnosed halitosis and periodontitis, , and that there is a continuation of services between the day program and the residence.	

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W 356	Continued From page 22 dental health, as follows: On July 17, 2008, at 8:03 AM, interview with direct care staff at the group home revealed Client #2 required assistance in all activities of daily living; including tooth brushing. Further interview with the group home staff indicated that the client's teeth often bled when they were brushed. Their statements were similar to those shared by day program staff. On July 17, 2008, at 1:15 PM, the Qualified Mental Retardation Professional (QMRP) indicated that Client #2 had an objective to improve his dental hygiene, which should be implemented in the mornings and evenings. Staff, however, were instructed to document the tooth brushing in the mornings only. The QMRP and the LPN Coordinator concurred that ideally, his teeth should be brushed after each meal. The LPN Coordinator further indicated that staff reported that the frequency of the gum bleeds had decreased since the June 2008 dental visit. Record review on July 17, 2008 revealed the client had a history of periodontitis, halitosis and accumulation of large deposits of calculus and plaque on his teeth. The review of the individual program plan (IPP) verified a goal to improve his personal care skills, as follows: "will brush his teeth using a battery-operated toothbrush with physical assistance from staff on 80% of trials recorded..." Further review of the IPP revealed instructions to"brush daily (2 x, but collect data on the am only)." Data collection reflected that the objective was documented in the mornings. A February 4, 2008 dental consultation report revealed "Large deposits of plaque and calculus	W 356	Client #2 IPP indicated to brush 2 X daily at home, and the 3rd time is supposed to be at the day program Mon through Friday; during the week client #2 is supposed to brush 3 times daily. The Qmrp has revised the IPP for client #3 to brush 3 X daily. Refer to attachment #6 It is the responsibility of the agency to ensure the coordination of the outside services rendered to the individuals. The Qmrp has contacted the day program coordinator to implement the brushing goal to assist client # 2 with toothbrushing while at the day program. 8-12-08 Furthermore,the nurse coordinator will attach a copy of the previous dental consult for the dentist to review prior to the examination. 8-08-08 In the future, the nursing staff, and Qmrp will ensure that the dentist provides the home with the current status of individual #2 diagnosed halitosis and periodontitis, and that there is a continuation of services between the day program and the residence.	

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W 356	Continued From page 23 present on all teeth surfaces. Gingival margins inflamed. Halitosis Periodontitis". The dentist stated that after the requested authorization was obtained, a return visit for full mouth scaling and polishing would be scheduled. On June 4, 2008 (four months later), the client received a full mouth scaling, with adult prophylaxis and polishing. Even though the client had calculus and continued periodontitis, the recommended tooth brushing regimen remained at 2 - 3 times daily. There was no evidence the client's existing dental care regimen had been effective. Even though the dentist's findings indicated that his oral hygiene had worsened, the facility failed to propose new strategies to improve his dental hygiene. 3. The facility failed to ensure the maintenance of Client #1's dental health, as follows: On July 17, 2008, at 2:56 PM, review of Client #1's dental records revealed that on September 19, 2007, the dentist performed generalized scaling. The dentist recommended brushing 2-3 times daily and a return visit in 6 months. The client returned 10 months later (July 6, 2008), at which time the dentist assessed "heavy calculus," with the recommendation for additional scaling. As with Client #2, Client #1 had a tooth brushing program. There was no evidence the client's existing dental care regimen had been effective. Even though the dentist's findings indicated that his oral hygiene had worsened, the facility failed to propose new strategies to improve his dental hygiene. In addition, the facility failed to schedule dental visits at the frequency ordered by the dentist.	W 356	Client #2 IPP indicated to brush 2 X daily at home, and the 3rd time is supposed to be at the day program Mon through Friday; during the week client #2 is supposed to brush 3 times daily. The Qmrp has revised the IPP for client #3 to brush 3 X daily. Refer to attachment #6 It is the responsibility of the agency to ensure the coordination of the outside services rendered to the individuals. The Qmrp has contacted the day program coordinator for the implementation of the brushing goal to assist client # 2 with toothbrushing while at the day program. 8-12-08 Furthermore,the nurse coordinator will attach a copy of the previous dental consult for the dentist to review prior to the examination. 8-08-08 In the future, the nursing staff, and Qmrp will ensure that the dentist provides the home with the current status of individual #2 diagnosed halitosis and periodontitis, and that there is a continuation of services between the day program and the residence. It is the responsibility of the agency to ensure the coordination of the outside services rendered to the individuals. The Qmrp has contacted the day program coordinator for the implementation of the brushing goal to assist client # 2 with toothbrushing while at the day program. 8-12-08 Furthermore,the nurse coordinator will attach a copy of the previous dental consult for the dentist to review prior to the examination. In the future, the nursing staff, and Qmrp will ensure that the dentist provides the home with the current the status of individual #2 diagnosed halitosis and periodontitis in writing.	
W 368	483.460(k)(1) DRUG ADMINISTRATION	W 368		

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W 368	Continued From page 24 The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that all medications were administered in accordance with physician's orders, for one of the two clients in the sample. (Client #1) The finding includes: Cross-refer to W331. Client #1's physician's orders included an order to administer Diastat 15 mg by injection and call 911 if he experienced a seizure lasting more than 3 minutes. Review of the client's record revealed that on November 29, 2007 and February 13, 2008 he had documented seizure activity lasting more than 3 minutes. He did not, however, receive the Diastat injection as ordered on either date.	W 368	Client # 3 diastat was not administrated due to the location of his seizure activities; the nursing staff was not in the facility; however, the facility has a seizure protocol to transport the individual to the ER, and activate 911 if necessary for prolonged seizures than 3 minutes or longer. The neurologist was contacted regarding possible alternative medication since seizures can not be predicted, and client #3 home is not a 24hrs nursing facility. The neurologist stated to take him to the ER for evaluation; The diastat order was discontinued by the PCP after consulting with the neurologist. 7-29-08 Refer to attachment # 1	
W 474	483.480(b)(2)(iii) MEAL SERVICES Food must be served in a form consistent with the developmental level of the client. This STANDARD is not met as evidenced by: Based on observation and record review, facility staff failed to provide foods in a form consistent with the developmental level of clients, for one of the four residents of the facility. (Client #3) The finding includes: On July 16, 2008, at approximately 4:07 PM, staff gave Client #3 a granola bar, broken in half. The	W 474		

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W 474	Continued From page 25 client placed into his mouth a large piece of (hard) granola bar; it was approximately 1 inch by 1 ½ inches in size. Posted nearby was a diet chart indicating that he was to receive "mechanical soft, bite sized portions" of food. Moments later, review of his July 2008 physician's orders confirmed that his foods should be mechanical soft, bite size. It should be noted that on July 17, 2008, at approximately 3:05 PM, review of staff training records revealed that staff had received training on diet plans, including food textures, within the past month (on June 27, 2008). The observation at snack time, however, indicated that the training had not been effective.	W 474	The staff were trained on clients diets on 6-27-08; howeve, the training was not effective. All staff were re-trained on the clients' diets including consistency and texture of specific diets. Refer to attachment # 7 In the future, the facility will ensure that the staff show the effectiveness of training through demonstration.	8-01-08
W 488	483.480(d)(4) DINING AREAS AND SERVICE The facility must assure that each client eats in a manner consistent with his or her developmental level. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that each client was allowed to eat in a manner consistent with his developmental level, for one of the two clients in the sample. (Client #2) The finding includes: On July 15, 2008, at 7:22 AM, Client #2 appeared to be visually impaired. He was observed making a "sweeping motion" with both hands across the table, back and forth repeatedly. Staff confirmed that he was visually impaired. At 7:25 AM, a staff was observed to tie a large bib around the client's neck as he sat at the dining table. Shortly before	W 488	The use of the bib was not recommended by any clinician, therefore was discontinued. In the future the facility will ensure that staff follow the feeding protocol only recommended by the clinician.	7-17-08

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W 488	Continued From page 26 he began eating his breakfast, staff placed one end of the bib underneath the plate, on the table top. He ate breakfast independently; however, staff provided constant supervision and frequent prompting to reduce his eating pace. On July 16, 2008, review of Client #2's feeding protocol, dated June 28, 2008, revealed that it did not include the use of a bib as a needed intervention. The protocol did provide staff instructions on how to reduce his eating pace instruct staff to staff portion of food into his mouth. Further review of the client's plan revealed no evidence that the interdisciplinary team had recommended the use of a bib at mealtimes.	W 488	The use of the bib was not recommended by a clinician, therefore it was discontinued. In the future the facility will ensure that staff follow the feeding protocol as recommended by the clinician.	7-17-08

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I 000	INITIAL COMMENTS A licensure survey was conducted from July 15, 2008 through July 17, 2008. A random sample of two residents was selected from a resident population of four men with various degrees of disabilities. The findings of this survey were based on observations at the group home and at two day programs, interviews with residents and staff as well as the review of clinical and administrative records, including incident reports.	I 000		
I 090	3504.1 HOUSEKEEPING The interior and exterior of each GHMRP shall be maintained in a safe, clean, orderly, attractive, and sanitary manner and be free of accumulations of dirt, rubbish, and objectionable odors. This Statute is not met as evidenced by: Based on observation and Interview, the GHMRP failed to maintain the interior of the facility in a clean, orderly, and attractive manner. The findings include: On July 17, 2008, beginning at 3:07 PM, observation of the environment revealed the following deficiencies: 1. The metal holder designed to support the shower head when it was not in use was broken. 2. Two brushes were observed laying inside the bathroom cabinet. Interview with the home manager revealed they were brushes for cleaning the commode. There was no evidence the brushes were stored in a sanitary manner between usage.	I 090	Received 8/1/08 GOVERNMENT OF THE DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH HEALTH REGULATION ADMINISTRATION 825 NORTH CAPITOL ST., N.E., 2ND FLOOR WASHINGTON, D.C. 20002 The metal holder designed to support the shower head was replaced. In the future, the facility will ensure that all of the equipments are in a working condition. The brushes were remived, and stored in the sanitary manner.	7-29-08 7-17-08

Health Regulation Administration

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

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I 090	Continued From page 1 3. Multiple cracked tiles were observed on the installed on the first floor in the area between the basement entrance door and the door exiting to the ramp of the facility.	I 090	The cracked tiles were repaired	7-29-08
	4. Insufficient lighting was observed the the following areas: (a) The pole lamp in the living room had two sockets that lacked light bulbs. (b) There was no light bulb in one of the two electrical sockets beside the door on the front porch. (c) The socket located on the ceiling of the utility room in the basement had no light bulb.		The light bulbs were replaced The light bulb of the door on the front porch was replaced. The light bulb on the ceiling of the utility room was replaced. In the future te facility will ensure that all of the electrical sockets have working liight bulbs.	7-17-08 7-17-08 7-18-08
	5. Observation of the area at the rear of the facility on July 15, 2008 at approximately PM revealed trash bags protruding above the top of the trash cans. Interview with the home manager revealed that the trash is picked up weekly on Wednesdays. There was no evidence that adequate trash cans were available for storage of trash/garbage for seven days.		More large trash cans will be purchased In the future, the facility will ensure that adequate trash cans are available for storage for seven days.	8-15-08
	6. Scaling paint was observed on the back wall of the basement near the bathroom and linen storage area. Interview with the home manager indicated the area was being repaired due to dampness on the wall after the heavy rains.		The scaling paint was repaired	7-29-08
	7. Observation of Client #3 on July 17, 2008 at revealed he required maximum support (lifting) by staff to get on (8:20 AM) and off (3:30 PM) the van. Interview with the home manager at approximately 8:30 AM indicated that running boards were scheduled to be installed on July 17, 2008, however had to be rescheduled. Further observation and interview revealed no device designed to maximize the client's independence		The running boards have been installed In the future the facility will ensure that there are available devices designed to maximize the client's independence.	7-29-08

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I 090	Continued From page 2 when boarding the van was available.	I 090		
I 097	3504.8 HOUSEKEEPING No cleaning agent, bleach, insecticide or any other poisonous, dangerous, or flammable material shall be accessible to a resident where access to such substance is contraindicated in the resident ' s Individual Habilitation Plan. This Statute is not met as evidenced by: Based on observation, the GHMRP failed to ensure that cleaning agents were stored in a location inaccessible to residents. The finding includes: On July 15, 2008, at 7:47 AM, a spray bottle of Simple Green Multi-Purpose Cleaner was observed being stored in an unlocked cabinet beneath the sink in the bathroom located on the main floor, nearest the residents ' bedrooms.	I 097	All caustic agents have been removed beneath the bathroom sink, and stored in a locked cabinet. In the future, the facility will ensure that all caustic agents are properly stored.	7-17-08
I 206	3509.6 PERSONNEL POLICIES Each employee, prior to employment and annually thereafter, shall provide a physician ' s certification that a health inventory has been performed and that the employee ' s health status would allow him or her to perform the required duties. This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to ensure that all staff obtained annual health certificates/ inventories.	I 206		

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	HFD03-0179	A. BUILDING _____ B. WING _____	07/17/2008

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I 206	Continued From page 3 The findings include: Review of the personnel records on July 17, 2008, beginning at 4:00 PM, revealed the following: 1. There were no current health certificates/ inventories provided for two direct care staff (S1 and S3). Further record review revealed that the health certificates had expired on April 4, 2008 and March 7, 2008 respectively. 2. There was evidence of a tuberculin screening (dated 2/5/08), however no health certificate/ inventory available for review for the nutritionist (C1). 3. The health certificate/ inventory provided for the occupational therapist (C2) had expired on May 25, 2008.	I 206	Staff S1, and S3 health certificates are on files see attached The Nutritionist haelth certificate is on file. see attached	
I 227	3510.5(d) STAFF TRAINING Each training program shall include, but not be limited to, the following: (c) Infection control for staff and residents; This Statute is not met as evidenced by: Based on staff interview and record review, the facility failed to effectively train staff to implement emergency measures for four of four residents residing in the facility. (Residents #1, #2, #3, and #4) The findings include: 1. The facility failed to maintain evidence of CPR certification for each staff as follows:	I 227		

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I 227	Continued From page 4 On July 17, 2008, review of staff and consultant records at approximately 4:30 PM, revealed no evidence of current Cardiopulmonary Resuscitation certification (CPR) for 2 of the 12 direct support staff (S1 and S2) and the (Qualified Mental Retardation Professional (QMRP). Interview with the QMRP revealed that he and the home manager had taken the CPR class on July 14, 2008, however the CPR cards or the attendance record were not yet available. Additionally, there was no evidence that a medication nurse (N1) had current CPR certification. The review of Resident #1's Individual Support plan dated July 7, 2007, revealed that staff should be trained in first aid and CPR to ensure the resident's safety.	I 227	The Qmrp and assistant house manager took the CPR/First Aid class on 7-12-08, but the cards are not availlable yet. See attached signature sheet. The house manager will take the class on 8-17-08	
I 379	3519.10 EMERGENCIES In addition to the reporting requirement in 3519.5, each GHMRP shall notify the Department of Health, Health Facilities Division of any other unusual incident or event which substantially interferes with a resident ' s health, welfare, living arrangement, well being or in any other way places the resident at risk. Such notification shall be made by telephone immediately and shall be followed up by written notification within twenty-four (24) hours or the next work day. This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to notify the Department of Health, Health Regulation Administration of an unusual incident that placed a resident's health at risk. (Resident #1)	I 379		

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I 379	Continued From page 5 The finding includes: On July 15, 2008, at 1:28 PM, Resident #1's day program Activities Coordinator was asked if the resident had experienced any unusual incidents or injuries. He directed this surveyor to the appropriate section of the resident's record. On February 7, 2008, the day program nurse documented on a Further Evaluation Report (FER) form that blood was seen in the toilet after Resident #1 had used it. He was then assessed by the nurse "and blood was noted in his rectal area. Could not see whether or not he has hemorrhoids. Please re-evaluate and treat accordingly." On July 17, 2008, at 4:00 PM, review of Resident #1's nurse progress notes in the residence revealed the following entry, dated February 7, 2008: "Note from day program stating blood... continue to be monitored for blood in stool. Designated nurse was made aware." A February 8, 2008, 7:00 AM nurse progress note indicated "BM last night, no blood." At 4:50 PM, the LPN Coordinator/ Designated Nurse was asked about the bloody stool. She stated that day program staff had discovered blood in the commode; however, they had not been sure that it had come from Resident #1. She further stated that there had been no blood observed in his clothing. When this surveyor read a direct quote taken from the FER, in which the day program nurse wrote having seen blood "in his rectal area," the LPN Coordinator denied having seen the FER. The immediate-past QMRP was present at the time. She indicated that she had not been informed of a bloody stool. She further indicated that she had visited the day	I 379	Client # 3 was evaluated by the facility nurse based on the day program report of blood in stool, but no blood was present when he had bowel movement at home. To prevent the re-occurance of miscommunication, the nursing staff will follow-up on all incidents that are reported by the program to ensure appropriate medical intervention. All incidents from the day program will be reported, and investigated in accordance with facility policies. There will be a communication log between the day program and the facility to ensure that daily occurances are documented. The Qmrp will have a dialogue with the nurse during the site observations In the future All incidents from the day program will be reported, and investigated in accordance with facility policies. Client # 3 was evaluated by the facility nurse based on the day program report of blood in stool, but no blood was present when he had bowel movement at home. To prevent the re-occurance of miscommunication, the nursing staff will follow-up on all incidents that are reported by the program to ensure appropriate medical intervention. All incidents from the day program will be reported, and investigated in accordance with facility policies. There will be a communication log between the day program and the facility to ensure that daily occurances are documented. The Qmrp will have a dialogue with the nurse during the site observations In the future All incidents from the day program will be reported, and investigated in accordance with facility policies.	

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I 379	Continued From page 6 program on February 11, 2008 (4 days after the incident) and the bloody stool had not been brought to her attention. The QMRP and LPN Coordinator both acknowledged that Resident #1's bleeding episode had not been reported to their administrator or to the Health Regulation Administration, as it had not been perceived by the facility as an injury of unknown origin.	I 379	Client # 3 was evaluated by the facility nurse based on the day program report of blood in stool, but no blood was present when he had bowel movement at home. To prevent the re-occurance of miscommunication, the nursing staff will follow-up on all incidents that are reported by the day program to ensure appropriate medical intervention. All incidents from the day program will be reported, and investigated in accordance with facility policies. In the future, all incidents of unknown origin will be reported to the administrator, and the Health Regulatory agency.	
I 399	3520.2(i) PROFESSION SERVICES: GENERAL PROVISIONS Each GHMRP shall have available qualified professional staff to carry out and monitor necessary professional interventions, in accordance with the goals and objectives of every individual habilitation plan, as determined to be necessary by the interdisciplinary team. The professional services may include, but not be limited to, those services provided by individuals trained, qualified, and licensed as required by District of Columbia law in the following disciplines or areas of services: (i) Speech and language therapy; and... This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to ensure that a copy of professional credentials was maintained for each individual providing professional services at the GHMRP, as required by District of Columbia law, in the following disciplines or area: (i) Speech and Language Therapy. The finding is:	I 399		

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I 399	Continued From page 7 Review of the personnel records on July 17, 2008, beginning at 4:30 PM, revealed the GHMRP failed to provide evidence that a current license/ professional certification was available for consultant C3, the Speech and Language Pathologist. At approximately 5:15 PM, interview with the Qualified Mental Retardation Professional verified that the license/ professional credentialing for the Speech Language was not available for review at the facility.	I 399	The provider is no longer using the services of the former Speech and Language Pathologist.	
I 401	3520.3 PROFESSION SERVICES: GENERAL PROVISIONS Professional services shall include both diagnosis and evaluation, including identification of developmental levels and needs, treatment services, and services designed to prevent deterioration or further loss of function by the resident. This Statute is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure nursing services in accordance with Resident #1's needs. The findings include: 1. On July 15, 2008, the morning medication pass was observed, beginning at 6:57 AM. Resident #1 received his medications at 7:10 AM. Depakote, Topamax and Keppra were among the medications he received. The medication nurse indicated that these medications (plus Tegretol in the evening) were for the control of seizures. This was verified afterwards, at 8:15 AM, by review of the resident's July 2008 physician's orders (POs). Resident #1's POs also reflected the following:	I 401	Client # 3 diastat was not administrated due to the location of his seizure activities; the nursing staff was not in the facility; however, the facility has a seizure protocol to transport the individual to the ER, and activate 911 if necessary for prolonged seizures than 3 minutes or longer. The neurologist was contacted regarding possible alternative medication since seizures can not be predicted, and client #3 home is not a 24hrs nursing facility. The neurologist stated to take him to the ER for evaluation; The diastat order was discontinued by the PCP after consulting with the neurologist. Refer to attachment # 1	7-29-08

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I 401	Continued From page 8 "Diastat 15 mg Acudial, Insert 1 syringe (15 mg) for seizures lasting more than 3 minutes. Patient to go to ER via 911." On July 16, 2008, Resident #1's neurology and seizure records were reviewed, beginning at 4:45 PM. His seizure protocol (not dated) reflected the order for Diastat and calling 911 for seizures lasting more than 3 minutes. Further review of the resident's chart, however, revealed a repeated failure to administer a Diastat injection following seizure activity, as follows: a. The resident was hospitalized on November 29, 2007 after experiencing multiple (5) seizures, including: 4 minutes at 10:06 AM and 4 minutes at 11:30 AM. Review of the resident's Medication Administration Record (MAR) for November 2007 and relevant Incident and investigation reports failed to show evidence that Diastat was administered. [Note: Diastat was first ordered, at 10 mg, beginning on January 24, 2007.] b. Previously, Resident #1 had experienced a 3-minute seizure on September 4, 2007. At that time, the resident was not administered Diastat. The neurologist wrote a note to the facility on the corresponding consultation report, on the same date, reminding nurses that he was to receive Diastat. c. The resident was again hospitalized on February 13, 2008 after experiencing multiple seizures: 4 minutes at 9:02 AM and 5 minutes at 12:18 PM. Review of the resident's Medication Administration Record (MAR) for February 2008	I 401	Refer to W 332 P.16 Refer to W 332 P.16 Client #3 seizures occured at different locations; for instance,he had seizures in route to his day program program, at the PCP's office as well, and at the ER; he spent the night at the hospital, and had no more seizures as per discharge report.	7-29-08 7-29-08

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I 401	Continued From page 9 and relevant incident reports and investigations failed to show evidence that Diastat was administered. On that same day, the dose of Diastat was increased from 10 mg to 15 mg after he experienced these seizures. d. On July 17, 2008, beginning at 10:16 AM, review of Resident #1's primary care physician (PCP) notes revealed no evidence that nurses informed the PCP that the resident had not been administered Diastat as ordered, on the 3 seizure events referenced above. e. On July 17, 2008, review of Resident #1's nursing records failed to show documented evidence that the nursing team had discussed the repeated failure to administer Diastat in accordance with POs. f. On July 17, 2008, beginning at 11:34 AM, the LPN Coordinator and the RN/Director of Nursing were interviewed in the facility. The Diastat cartridge and syringe were locked in the medication cabinet. The LPN Coordinator stated that they remained secured under lock and key at all times, with keys held only by nursing staff. 1) The LPN Coordinator unlocked the cabinet and presented the Diastat cartridge and syringe. She acknowledged that the medication was not accessible immediately should Resident #1 experience a seizure when there was no nurse present in the facility. 2) The LPN Coordinator indicated that the facility was unable to ensure that a nurse could arrive within minutes of Resident #1 experiencing a seizure that lasted over 3 minutes. 3) The LPN Coordinator confirmed that on the 3	I 401	Client # 3 PCP was aware that he did not receive diastat during his seizure activities because he was in route to his day program; he had seizures at her office. The PCP contacted the neurologist her office. The PCp contacted the neurologist who recommended to take client # 3 to the ER for evaluation. Currently the diastat order is being discontinued. Refer to W 332 P.16 Client # 3 diastat was not administrated due to the location of his seizure activities; the nursing staff was not in the facility; however, the facility has a seizure protocol to transport the individual to the ER, and activate 911 if necessary for prolonged seizures than 3 minutes or longer. The neurologist was contacted regarding possible alternative medication since seizures can not be predicted, and client #3 home is not a 24hrs nursing facility. The neurologist stated to take him to the ER for evaluation; The diastat order was discontinued by the PCP after consulting with the neurologist. Refer to attachment # 1 Refer to W 331 (d) P.19 The diastat can only be administrated by a nurse; hense it was safely locked in the cabin Client # 3 did not receive diastat during his seizure activities because he was in route to his day program; he had seizures at the PCP office; the PCP contacted the neurologist who recommended to take client # 3 to the ER for evaluation. Currently the diastat order is discontinued.	7-29-08 7-29-08 7-29-08 7-29-08

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I 401	Continued From page 10 dates listed above, Resident #1 did not receive the Diastat injection as ordered. 4) The LPN Coordinator and the RN/Director of Nursing stated that they had discussed this issue among themselves, then acknowledged that they had not brought up the topic with the PCP. 5) The LPN Coordinator and the RN/Director of Nursing also acknowledged that they had not discussed the topic with the neurologist. 6) When asked if the medication was available at Resident #1's day program, the LPN Coordinator and the RN/Director of Nursing both stated that they had not checked with the day program. They added, however, that neither had delivered the medication to the day program themselves. 7) Resident #1's day program was contacted by telephone on July 17, 2008, at 12:10 PM. The day program RN indicated that the topic had been discussed "a long time" earlier. During the telephone call, she looked in their medication supply and reported having found no evidence of a Diastat cartridge with syringe. She then stated "they didn't bring it." Facility nurses failed to establish a means of ensuring that Resident #1's Diastat medication could be administered in accordance with physician's orders.	I 401	Client # 3 PCP was aware that he did not receive diastat during his seizure activities because he was in route to his day program; he had seizures at her office as well. The PCP contacted the neurologist who recommended to take client # 3 to the ER for evaluation. Currently the diastat order is discontinued. The neurologist was contacted on 7-15-08 regarding the diastat order that has not been administered due to the location of the seizures activities that lasted 3 minutes or longer. The neurologist responded to send client # 3 to the ER when there is no nurse to administer the diastat. Client #3 day program never discussed his diastat order with his home nurse; however, in the future, the facility nurse will ensure that PRN medications are available a the day program.	
I 500	3523.1 RESIDENT'S RIGHTS Each GHMRP residence director shall ensure that the rights of residents are observed and protected in accordance with D.C. Law 2-137, this chapter, and other applicable District and federal laws.	I 500		

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I 500	Continued From page 11 This Statute is not met as evidenced by: 1. Based on interview and record review, the GHMRP failed to consistently implement the dentist's recommendations to promote residents' dental health, as follows: a. On July 17, 2008, at 8:03 AM, interview with direct care staff at the group home revealed Resident #2 required assistance in all activities of daily living, including tooth brushing. Further interview with the group home staff indicated that the resident's teeth often bled when they were brushed. Their statements were similar to those shared by day program staff. On July 17, 2008, at 1:15 PM, the Qualified Mental Retardation Professional (QMRP) indicated that Resident #2 had an objective to improve his dental hygiene, which should be implemented in the mornings and evenings. Staff, however, were instructed to document the tooth brushing in the mornings only. The QMRP and the LPN Coordinator concurred that ideally, his teeth should be brushed after each meal. The LPN Coordinator further indicated that staff reported that the frequency of the gum bleeds had decreased since the June 2008 dental visit. Record review on July 17, 2008 revealed the resident had a history of periodontitis, halitosis and accumulation of large deposits of calculus and plaque on his teeth. The review of the individual program plan (IPP) verified a goal to improve his personal care skills, as follows: "will brush his teeth using a battery-operated toothbrush with physical assistance from staff on 80% of trials recorded..." . Further review of the IPP revealed instructions to"brush daily (2 x, but	I 500	Client #2 IPP indicated to brush 2 X daily at home, and the 3rd time is supposed to be at the day program Mon through Friday; during the week client #2 is supposed to brush 3 times daily. The Qmrp has revised the IPP for client #3 to brush 3 X daily. Refer to attachment #6 It is the responsibility of the agency to ensure the coordination of the outside services rendered to the individuals. The Qmrp has contacted the day program coordinator to implement the brushing goal to assist client # 2 with toothbrushing while at the day program. 8-12-08 Furthermore,the nurse coordinator will attach a copy of the previous dental consult for the dentist to review prior to the examination. 8-08-08 In the future, the nursing staff, and Qmrp will ensure that the dentist provides the home with the current status of individual #2 diagnosed halitosis and periodontitis, and that there is a continuation of services between the day program and the residence.	

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I 500	Continued From page 12 collect data on the am only)." Data collection reflected that the objective was documented in the mornings. A February 4, 2008 dental consultation report revealed "Large deposits of plaque and calculus present on all teeth surfaces. Gingival margins inflamed. Halitosis Periodontitis". The dentist stated that after the requested authorization was obtained, a return visit for full mouth scaling and polishing would be scheduled. On June 4, 2008 (four months later), the resident received a full mouth scaling, with adult prophylaxis and polishing. Even though the resident had calculus and continued periodontitis, the recommended tooth brushing regimen remained at 2 - 3 times daily. There was no evidence the resident's existing dental care regimen had been effective. Even though the dentist's findings indicated that his oral hygiene had worsened, the facility failed to propose new strategies to improve his dental hygiene. b. On July 17, 2008, at 2:56 PM, review of Resident #1's dental records revealed that on September 19, 2007, the dentist performed generalized scaling. The dentist recommended brushing 2-3 times daily and a return visit in 6 months. The resident returned 10 months later (July 6, 2008), at which time the dentist assessed "heavy calculus," with the recommendation for additional scaling. As with Resident #2, Resident #1 had a tooth brushing program. There was no evidence the resident's existing dental care regimen had been effective. Even though the dentist's findings indicated that his oral hygiene had worsened, the facility failed to propose new strategies to improve his dental hygiene. In addition, the facility failed to schedule dental visits at the frequency ordered by the dentist.	I 600	Client #2 IPP indicated to brush 2 X daily at home and the 3rd time is supposed to be at the day program Mon through Friday; during the week client #2 is supposed to brush 3 times daily. The Qmrp has revised the IPP for client #3 to brush 3 X daily. Refer to attachment #6 It is the responsibility of the agency to ensure the coordination of the outside services rendered to the individuals. The Qmrp has contacted the day program coordinator to implement brushing goal to assist client # 2 with toothbrushing while a the day program. Furthermore,the nurse coordinator will attach a copy of the previous dental consult for the dentist to review prior to the examination. In the future, the nursing staff, and Qmrp will ensure that the dentist provides the home with the current status of individual #2 diagnosed halitosis and periodontitis in writing, and that there is a continuation of services between the day program and the residence. It is the responsibility of the agency to ensure the coordination of the outside services rendered to the individuals. The Qmrp has contacted the day program coordinator for the implementation of the brushing goal to assist client # 2 with toothbrushing while at the day program. Furthermore,the nurse coordinator will attach a copy of the previous dental consult for the dentist to review prior to the examination. In the future, the nursing staff, and Qmrp will ensure that the dentist provides the home with the current status of individual #2 diagnosed halitosis and periodontitis in writing.	8-12-08 8-08-08 8-12-08

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD03-0179	A. BUILDING _____ B. WING _____	07/17/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
R C M OF WASHINGTON	1307 45TH PLACE, SE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 500	Continued From page 13 2. Based on observation and record review, GHMRP staff failed to provide foods in a form consistent with Resident #3's prescribed dietary orders, as follows: On July 15, 2008, at approximately 4:07 PM, staff gave Resident #3 a granola bar, broken in half. The resident placed into his mouth a large piece of (hard) granola bar; it was approximately 1 inch by 1 ½ inches in size. Posted nearby was a diet chart indicating that he was to receive "mechanical soft, bite sized portions" of food. Moments later, review of his July 2008 physician's orders confirmed that his foods should be mechanical soft, bite size. It should be noted that on July 17, 2008, at approximately 3:05 PM, review of staff training records revealed that staff had received training on diet plans, including food textures, within the past month (on June 27, 2008). The observation at snack time, however, indicated that the training had not been effective. 3. Based on interview and record review, GHMRP nurses failed to establish a means of ensuring that Resident #1's Diastat medication could be administered in accordance with physician's orders. Cross-refer to I401. 4. Based on observation, the facility failed to ensure the confidentiality of personal information, for four of the four residents of the facility (and all other individuals served by the agency), as follows: a. On July 15, 2008, at approximately 6:45 AM, a diet chart was observed posted openly on the refrigerator door in the kitchen. It listed the	I 500	The staff were trained on dlients diets on 6-27-08;however the training was not effective. All staff were re-trained on the clients' diets including consistency and texture of specific diets. Refer to attachment # 7 In the future, the facility will ensure that the staff show the effectiveness of training through demonstration. Client #3 day program never discussed his diastat order with his home nurse; however, in the future, the facility nurse will ensure that PRN medications are available a the day program.	8-01-08

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FORM APPROVED

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I 500	Continued From page 14 specialized, prescribed diets for all four of the residents, including Resident #4's mealtime protocol that addressed reflux, regurgitation and other dietary concerns. b. On July 15, 2008, at approximately 8:00 AM, review of the Medication Administration Record (MAR) book following observation of the morning medication pass revealed that it included a listing of all individuals receiving residential services through RCM of Washington. The list showed the full names, social security numbers, dates of birth and other personal information for residents of all group homes and supervised apartment settings. Based on interview and record review, the facility failed to implement policies that ensured the health and safety of two of the four residents in the sample. (Residents #1 and #2) The findings include:	I 500	All of the individuals' diets were removed from the front of the refrigerator In the future the facility management will ensure that the individuals' s information are kept confidentially or unconspiciously. staff were trained on privacy and confidentiality. Refer to attachment 32 al of the individual information were removed from the MAR, and kept in a confidentially. In the future the facility management will ensure that the individuals' s information are kept confidentially or unconspiciously.	7-17-08 7-17-08